No. 82-292

Office - Supreme Court, U.S.
FILED
AUG 18 1982
ALEXANDER L. STEVAS,
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1982

CONSULTANTS AND ADMINISTRATORS, INC.,
an Illinois corporation,

Petitioner,

v.

DEPARTMENT OF INSURANCE OF THE STATE OF ILLINOIS, PHILIP R. O'CONNOR, Its Director, and ILLINOIS VISION SERVICES PLAN,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE APPELLATE COURT OF ILLINOIS, FIRST DISTRICT

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QUESTION PRESENTED

This case presents an important issue involving federal preemption: whether, in light of the express federal preemption of any state regulation which "relates to an employee benefit plan" contained in the Employee Retirement Security Act of 1974 ("ERISA"), the Appellate Court of Illinois improperly upheld the Illinois Department of Insurance ruling that the Illinois Voluntary Health Services Plans Act applied to the petitioner's acts, as an agent and "named fiduciary" of an employee benefit plan subject to regulation under ERISA, in setting up and administering a dental and vision care facility.

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PETITION FOR A WRIT OF CERTIORARI TO THE APPELLATE COURT OF ILLINOIS, FIRST DISTRICT

Petitioner, Consultants and Administrators, Inc., petitions for a writ of certiorari to review the decision of the Appellate Court of Illinois in upholding the order of the Illinois Department of Insurance applying the Illinois Voluntary Health Services Plans Act to petitioner.

OPINIONS BELOW

The opinion of the Illinois Appellate Court (App. A) is reported at 103 Ill. App. 3d 920, 431 N.E.2d 1306 (1982). The order denying leave to appeal to the Supreme Court of Illinois (App. B) is not reported.

JURISDICTION

The decision of the Illinois Appellate Court (App. A) was entered on January 12, 1982. The decision of the Supreme Court of Illinois denying leave to appeal (App. B) was entered on May 28, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(3).

STATUTES INVOLVED

The applicable constitutional and statutory provisions are reproduced in Appendix I.

STATEMENT

This controversy arises out of the services of Consultants and Administrators, Inc. ("C & A") which administers dental and optometric services on behalf of The Chicago Newspaper Publishers Association-Drivers Union Hospital and Medical-Surgical Trust ("the Trust"). The Trust was established by agreement between the Chicago Tribune Company, Field Enterprises, Inc., Newspaper Division ("the employers") and the Newspaper, Magazine, Periodical, Salesmen, Drivers, Chauffeurs, Division Men, District Managers, Checkers, Vendors, and Handlers Union, Local 706, International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, and six individual trustees. (R. 189-214.)[1] The terms of the

[1] Record references will be indicated as follows: "R. ..."

Trust were arrived at by collective bargaining and require the employers to contribute to a fund which is used to provide certain medical benefits including dental and optical care benefits. (R. 189, 197.) The Appellate Court recognized and the Illinois Department of Insurance ("the Department") conceded that the Trust is an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 ("ERISA"). (App. A, 2a.)

In 1976, C & A entered into a contract with the Trust which provided, *inter alia*, as follows:

> C & A hereby agrees to provide under the terms and conditions hereinafter set forth facilities for a dental care program and an optometric and vision care program, which shall include such dental care and optometric and vision care of Participants and Dependents as set forth herein.

(App. G, 24a; R. 215, ¶ 3.) Under the contract, C & A is designated a "named fiduciary" of the Trust with respect to these services. (App. G, 29a; R. 219, ¶ 19.)

The trustees of the Trust continue to have control over the manner in which C & A is to assist in providing services. (App. G, 24a-29a; R. 215-220.) The trustees have a right to determine the hours during which services are provided (App. G, 24a; R. 216, ¶ 4), to determine the order and nature of the priority among the types of services to be rendered (App. G, 25a; R. 216, ¶ 8), and to inspect both the facility and the work to determine the quality of performance (App. G, 25a-26a; R. 212, ¶¶ 9, 10). The contract also specifies that C & A must implement the trustees' recommendations regarding services or they may be terminated within 30 days. (App. G, 25a-26a; R. 217, ¶¶ 9-11.) C & A is paid $16.25 per month for each

qualified participant in the dental and vision plan. (App. G, 28a; R. 218, ¶ 17.) Teh key element of the contract is the establishment of a separate facility where employees who are qualified for benefits can go to receive dental care and optometric and vision care. (App. G, 24a; R. 216, ¶ 4.)

The Illinois Department of Insurance Proceedings.

In 1979, the contract between the Trust and C & A was about to be considered for renewal. (R. 57-59.) Respondent Illinois Vision Services Plan, a business which provides vision care service to subscribers and which is incorporated under the Illinois Vision Service Plan Act, Ill. Rev. Stat. ch. 32, §§ 651 et seq., desired to bid on a new agreement with the Trust. In February of 1979, Illinois Vision Services Plan requested that the Director of the Department investigate C & A. (R. 57-59.)

In July 1979, the Department of Insurance informed C & A that C & A's activities on behalf of the Trust violated the Illinois Vision Service Plan Act and the Illinois Dental Service Plan Act. (Ill. Rev. Stat. ch. 32, §§ 690.1 et seq.) (R. 226.) Following this notification, a hearing officer was appointed and the Department notified C & A of a hearing. (R. 45-49.)

C & A filed a motion to dismiss the proceeding, asserting that the Department had no jurisdiction over C & A because C & A was acting on behalf of an employee benefit plan, and, hence, the preemption provisions of § 514(a) of ERISA, 29 U.S.C. § 1144(a), precluded state regulation. (App. H, 31a-32a; R. 10-11, 68-69.) The Department opposed the motion to dismiss. (R. 71-72.) The Department's hearing officer denied the motion to dismiss on October 11, 1979. (R. 73-74.)

At the subsequent regulatory hearing, one witness testified, the Assistant Deputy Director of the Department. His only testimony was that in his opinion C & A's activities fell within the terms of Illinois Voluntary Health Services Plans Act, ("the Illinois Act"), Ill. Rev. Stat. ch. 32, §§ 595 et seq. (R. 107-140.)

Stating no reasons, the hearing officer recommended dismissal of the proceeding without prejudice, for further investigation. (App. E; R. 9.) The Director of the Department rejected the hearing officer's recommendation and issued an opinion concluding that C & A had failed to obtain a charter from the Department as required by Section 8 of the Voluntary Health Services Plans Act, Ill. Rev. Stat. ch. 32, § 602. The Department ordered immediate compliance. (App. F; R. 5-8.)

Many of the requirements of the Trust's contract with C & A will be nullified if C & A is required to comply with the provisions of the Illinois Act. For example, to comply with the Illinois Act, C & A will be required to contract directly with the employees; it could not contract with the employee benefit plan's trustees. Ill. Rev. Stat. ch. 32, § 606. Despite the fact that it arranges for dental and vision care services only, it will be required to have a Board of Directors which includes 30% medical doctors. Ill. Rev. Stat. ch. 32, § 599. C & A will be required to allow the employees who are seeking vision care to elect between optometrists hired by C & A and medical doctors not under contract with C & A. If an outside medical doctor is elected, C & A will be required to reimburse that doctor. Ill. Rev. Stat. ch. 32, § 609.10.

Proceedings in the Circuit Court.

On appeal of the Department's order in the Circuit Court of Cook County, C & A again asserted that the Department was without authority to regulate C & A's activities on behalf of the Plan because of the preemption provisions of ERISA. (R. 3, ¶ (b)(1); R. 301, ¶ (1); R. 302-304; see also transcript following R. 339 at 5, 8.) The Circuit Court affirmed the decision of the Department but stayed its order for 30 days. (App. D, 11a-12a; R. 331, Order of Jan. 7, 1981.) After C & A moved for rehearing or modification of the order to include findings of fact and conclusions of law, the Circuit Court modified its opinion, adopting the Department's proposed findings of fact and conclusions of law. (App. C, 10a; R. 337, Order of Jan. 30, 1981.) None of the findings or conclusions related to C & A's claim that ERISA preempted the Illinois law.

The Appellate Court Ruling.

C & A appealed the decision of the Circuit Court to the Appellate Court of Illinois, First District. C & A again argued that it was exempt from Illinois regulation by reason of the preemption provisions of ERISA. The Appellate Court affirmed the decision of the Circuit Court. It ruled only that the statutory terms of the Illinois Health Services Plans Act covered C & A's activities. Although the Court specifically ruled that the Trust was an employee benefit plan (App. A, 2a), it did not reach the issue of ERISA preemption. The Appellate Court stated that it would not "establish new Illinois precedent on a question of weighty significance" on the basis of the briefs before it. (App. A, 5a-6a.) Leave to appeal the Appellate Court's decision to the Supreme Court of Illinois was denied by order dated May 28, 1982. (App. B, 9a.)

REASONS FOR GRANTING THE WRIT

The central purpose of ERISA is to provide for all employee benefit plans a uniform system of federal regulation free from state interference. That uniformity is threatened by the regulation which the State of Illinois is attempting to impose over the manner in which C & A as an agent for a plan may administer collectively bargained for dental and vision care services.

The scope of the preemption provision of ERISA and the latitude which remains to the states to regulate the conduct of agents and fiduciaries of employee benefit plans are matters of national importance which require this Court's clarification.

The decision of the Appellate Court of Illinois failed to address the petitioner's repeated claims of ERISA preemption. The decision below will seriously undermine the statutory intent, confirmed by *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), to create broad and exclusive federal governance of employee benefit plans.

Moreover, to the extent the order turned on a legal determination that C & A was engaged in the business of insurance and therefore excluded from the preemption provision of ERISA, that decision is in conflict with the recent decisions of this Court in *Union Labor Life Insurance Company* v. *Pireno*, ... U.S. ....., 50 U.S.L.W. 4911 (June 28, 1982), and *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), which narrowly construe the definition of the "business of insurance" contained in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. Under these cases, administration of dental and vision care services and facilities does not fall within

the "business of insurance." Uniform application of the federal laws requires that the definition of the "business of insurance" contained in ERISA be identical to the definition of the "business of insurance" in the McCarran-Ferguson Act as recently clarified in *Pireno* and *Royal Drug*.

1. The Decision of the Illinois Appellate Court Is Inconsistent With Prior Decisions of This Court and the Lower Federal Courts Giving Broad Scope to the ERISA Preemption Provisions.

To insure uniform development and application of the regulatory scheme, § 514 of ERISA (29 U.S.C. § 1144) provides that all state laws which "relate to an employee benefit plan" shall be preempted.[2]

C & A is both a named fiduciary and an employer as defined in ERISA.[3] Its conduct in both capacities is specifically governed by ERISA. ERISA establishes standards of conduct, responsibility and obligations for employers and fiduciaries of employee benefit plans. Congress unequivocally expressed its intent to preclude state regulation of those governed by the Act.

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[2] Section 514 of ERISA reads in part:

> Except as provided in subsection (b) of this Section, the provisions of this title and title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b).

[3] Section 3(5) of ERISA (29 U.S.C. § 1002(5)) defines an "employer" to mean "any person acting directly as an employer or indirectly in the interest of an employer in relation to an employee benefit plan."

Moreover, ERISA preempts not only state laws inconsistent with its provisions, or laws which seek to regulate the areas comprehensively occupied by ERISA, but also any law which relates to an employee benefit plan. Congress repeatedly rebuffed attempts to narrow the preemption provision.

The Conference Committee and Congress as a whole rejected proposals to preempt only duplicative or inconsistent state statutes in favor of preemption of the entire field of employee benefit plan regulation.[4] For example, Senator Jacob Javits, the ranking minority member of the committee which initiated the first ERISA bill, arguing against a narrow preemption provision, said:

> [T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.

120 Cong. Rec. 29942 (1974). *See also* statement of Senator Harrison Williams, 120 Cong. Rec. 29933 (1974) (the preemption provision was intended to apply in the broadest sense with only the exceptions specified in the Act).

This Court, as well as the lower federal courts, has ruled that the broad scope of ERISA's preemption provision requires that, when a state statute is challenged, the court must look beyond the stated purpose of the state regulation, to determine whether it has any direct or indirect impact on an employee benefit plan. In *Alessi* v.

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[4] The House version of H.R. 2 enacted in February, 1974 had a limited preemption provision. 120 Cong. Rec. 4742 (1974). A limited preemption provision was also found in the Senate version of H.R. 2, passed on March 4, 1974. 120 Cong. Rec. 5002 (1974).

Raybestos-Manhattan, Inc., 451 U.S. 504 (1981), this Court held that, as a result of ERISA's preemption provision, New Jersey could not prohibit a pension plan from reducing benefits based on a beneficiary's receipt of workers' compensation:

> ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. . . . ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision.

451 U.S. at 525.

In *Stone & Webster Engineering Corp.* v. *Ilsley*, 518 F. Supp. 1297 (D. Conn. 1981), the district court applied the *Alessi* decision and invalidated a state statute which required an extension of health care benefits for a prescribed period following an individual's employment. An analogous provision can be found in the Illinois Act which requires that employees be given conversion privileges permitting individual participation in the health plan when employment is terminated. Ill. Rev. Stat. ch. 32, § 609.5.

In *Standard Oil Co. of California* v. *Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), recently affirmed by this Court, ... U.S. ....., 102 S. Ct. 79 (1981), the district court invalidated a statute which required employers to maintain health care plans meeting state prescribed standards. The attempted regulation in *Standard Oil Co.* was very close to the attempted regulation here. C & A is an employer as defined by ERISA itself and is a "named fiduciary" of an employee benefit plan. The Department is attempting to require both a method of operation and provision of specific benefits by C & A. Illinois' attempted regulation has a direct impact on an employee benefit plan.

In the seminal decision in *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978), a California statute which sought to regulate "health care service plans" was held to be preempted as applied to employee benefit plans. The preempted statute defined a "health care service plan" as "any person who undertakes to arrange for the provision of health care services . . . to subscribers or enrollees . . . in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees . . . ." *Id.* at 1296 (citing Cal. [Health & Safety] Code § 1345(f)). One of the options afforded by the benefit fund in *Hewlett-Packard Co.* was participation in a prepaid health and dental care plan. The court concluded that it was "indisputable" that ERISA intended to supersede the state regulation.[5]

The states cannot regulate the administration of collectively bargained for dental and vision care facilities and services on behalf of an employee benefit plan without running afoul of the language and intent of ERISA's broad preemption provision, as demonstrated by the consistent rulings of this Court and the lower federal courts. The Supremacy Clause of the Constitution, U.S. Const. art. VI, cl. 2, establishes the authority of Congress to displace state control of this entire field. *Florida Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132, 142-43 (1963).

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[5] Similarly, in *St. Paul Electrical Workers Welfare Fund* v. *Markman*, 490 F. Supp. 931 (D.Minn. 1980), Minnesota tried to require that specific coverage be provided under health care plans and that the plans meet reporting requirements. The district court ruled the state law attempting to regulate employers was preempted. In *National Carriers' Conference Committee* v. *Heffernan*, 454 F Supp. 914 (D.Conn. 1978), a statute which imposed a tax on an administrator of a plan, like C & A, was held to be preempted.

That is exactly what Congress undertook to accomplish by the broad preemption provision of ERISA.

Uniform application of the Act requires that this Court establish that ERISA preempts the Illinois Voluntary Health Services Plans Act "as it relates" to C & A's administration of an employee benefit plan.

2. C & A Is Not Engaged in the Business of Insurance, As Defined in ERISA and in the McCarran-Ferguson Act.

The Department placed heavy emphasis below upon the fact that C & A receives a monthly payment from the Trust based on the number of employees who are qualified to receive benefits. The Department previously asserted that the fact of these payments was evidence that C & A was in the business of insurance and therefore excluded from ERISA's preemption provision. (Brief of Respondent Department in the Appellate Court of Illinois, at 11.) But C & A serves as agent and fiduciary of the Trust, not as an insurer of dental and optical services. If the Trust had hired dental and optical personnel and provided a facility for their work, it is incontestable that the State of Illinois would be barred from regulating the services by the preemption provision of ERISA. The fact that C & A, as an agent of the Trust, provides the facility and administers the professional services is not a basis for treating the situation differently. The administration of services collectively bargained for is not the provision of insurance.

Section 514(2)(A) of ERISA specifies that the Act does not "exempt or relieve any person from any law of

any State which regulates insurance . . . ."[6] However, this provision does not permit Illinois to "deem" C & A an insurer.[7] C & A must actually be engaged in the business of insurance for the State to have the right to regulate its activities on behalf of an employee benefit plan.

The national policy of according primacy to state regulation of insurance was originally codified by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. The McCarran-Ferguson Act allows the states to "regulat[e] the business of insurance," *id.*, § 1012(b). This language is very similar to ERISA's exemption from preemtion of "law[s] . . . which regulate insurance" and the "deemer" provision which prohibits defining Plan activities as "the business of insurance." ERISA's exemption for the business of insurance is also premised on the same policy of deferring to state regulation in this field. Because the two statutes reflect the same basic policy, they are *in pari materia* and should be construed consistently. This Court has twice recently considered the scope of the McCarran-Ferguson Act language and has defined narrowly the "business of insurance" in a way that demonstrates that C & A should not be subjected to state regulation under the insurance exception to ERISA preemption.

In *Union Labor Life Insurance Co.* v. *Pireno*, ... U.S. ....., 50 U.S.L.W. 4911 (June 28, 1982), this Court concluded that the actions of a peer review committee deter-

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[6] § 514(2)(A) of ERISA provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities."

[7] § 514(2)(B) of ERISA provides that no employee benefit plan or any trust established under such plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies, insurance contracts . . . ."

mining whether chiropractors' charges under an insurance policy were "reasonable" and "necessary" fell outside the McCarran-Ferguson Act definition of the "business of insurance."

The *Pireno* ruling reflected the fact that the use of the peer review committee plays no part in the transfer of risk characteristic of insurance. *Id.* at ....., 50 U.S.L.W. at 4914. C & A's primary function is to administer the provision of dental and vision care services and facilities on behalf of an employee benefit plan. None of the administrative services it provides pertain in any way to any insurance industry practice. On the contrary, the fact that C & A assures the provision of facilities and services is a clear distinction from the reimbursement obligations normally undertaken by an insurer. The only risk spreading is the per capita monthly charge fixed in advance. This alone cannot render C & A an insurer, since any fixed contract price for services or goods acts to shift the risk of an increase in the cost of services or goods from the purchaser to the seller.

The control of prices for benefits was rejected as an activity falling within the parameters of the business of insurance in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). This Court found an agreement between an insurance company and pharmacies regarding the manner and size of payment for drugs under insurance policies to be outside "the business of insurance."

C & A's contractual obligations in this case fall more clearly outside the business of insurance than the practices this Court found to be beyond state regulation in *Royal Drug* and *Pireno*. Rental of facilities and negotiation of salaries by C & A are more peripheral to "the

business of insurance" than were the determination of eligibility for insurance reimbursement in *Pireno* or the payment for drugs under insurance policies in *Royal Drug*. C & A's administration of dental and health care facilities and services are not the business of insurance as defined by these cases and therefore there is no applicable exception to the preemption provision of ERISA.

The uniform application of ERISA and the uniform definition of the states' authority to regulate insurance is jeopardized by the erroneous ruling of the Illinois Appellate Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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